471-000-88 Nebraska Medicaid Dental Program completion instructions for the 2002, 1999 and 1994 ADA Dental Claim Forms

The instructions in this appendix apply when submitting a prior authorization request and when billing Nebraska Medicaid.

- Instructions for the 2002 ADA form are on page 3 of 14.
- Instructions for the 1999 ADA form are on page 7 of 14.
- Instructions for the 1994 ADA form are on page 11 of 14.
- Electronic Claims: Dental services may be billed to Nebraska Medicaid using the standard electronic Health Care Claim: Dental transaction (ASC X12N 837). For electronic transaction submission instructions, see 471-000-50.

Prior Authorization: To request prior authorization, **c**omplete the fields designated with one asterisk (*). Send TWO copies of the ADA claim form and required documentation to:

Medicaid Division
Department of Health & Human Services Finance & Support
P.O. Box 95026
Lincoln, NE 68509

- Electronic Submission: Dental prior authorization requests may be requested and issued using the standard electronic Health Care Service Review – Request for Review and Response (ASC X12N 278). For instructions, see Standard Electronic Transactions at 471-000-50.

Payment: To claim payment for completed services, complete the fields designated with two asterisk (**) and one asterisk (*). Send ONE copy of the ADA claim form to:

Medicaid Claims Processing
Department of Health & Human Services Finance & Support
P.O. Box 95026
Lincoln, NE 68509

General Billing Instructions:

- A MAXIMUM of 15 lines of service can be submitted on a claim. Complete a second form if treatment exceeds 15 lines of service.
- Each page/claim form must be submitted with a “Total Fee” for that page.
- When submitting for payment, if some services listed on the claim were not completed, line through those items and correct the “Total Fee.”
- DO NOT list services that have a $0.00 fee.

Eligibility: Medicaid eligibility and third party resources may be verified from –

1. The client’s monthly Nebraska Medicaid Card or Nebraska Health Connection ID Document. For explanation and examples, see 471-000-123;
2. The Nebraska Medicaid Eligibility System (NMES) voice response system. For instructions, see 471-000-124; or
3. The standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). For electronic transaction submission instructions, see 471-000-50.

Unborn-Ineligible Mother of an Eligible Unborn: The mother is eligible for dental services under the unborn-Medicaid number during and for a period of time after the pregnancy ends. Medicaid coverage on the unborn Medicaid number ends on the last day of the month in which the 60-day period (beginning on the last day of her pregnancy) ends. All prior authorization regulations apply.

Share of Cost: Certain Medicaid clients are required to pay or obligate a portion of their medical costs due to excess income. These clients receive Form EA-160, "Record of Health Cost – Share of Cost – Medicaid Program" from the local HHS office to record services paid or obligated to providers. For an example and instructions on completing this form, see 471-000-79.

Presumptive Eligibility: Certain Medicaid clients are issued a Nebraska Medicaid Presumptive Eligibility Application at the time the client is determined eligible by a qualified presumptive eligibility provider. Presumptive eligibility may begin or end on any day of the month. For information regarding the Nebraska Medicaid Presumptive Eligibility document see 471-000-123.

Telehealth: The 1999 ADA dental claim form must be used when billing Telehealth services. See the instructions on page 8 of 14 for Telehealth billing instructions. Medicaid policy regarding Telehealth services is covered in 471 NAC 1-006.

Encounter Visits: Tribal/IHS dental clinics and FQHC dental clinics – submit code T1015 when billing an encounter. The claim must also contain the ADA procedure code for service(s) provided.

Third Party Resources: Claims for services provided to clients with third party resources (e.g., private health/casualty insurance) must be billed to the third party payer according to the payer's instructions. After the payment determination by the third party payer is made, the provider may submit the claim to Nebraska Medicaid. A copy of the explanation of benefits, remittance advice, denial, or other documentation from the third party resource must be submitted with the claim.

Medicaid Claim Status: The status of Nebraska Medicaid claims submitted for payment can be obtained by using the standard electronic Health Care Claim Status Request and Response transaction (ASC X12N 276/277), or by contacting Medicaid Inquiry at 1-877-255-3092 or 471-9128 (in Lincoln). Medicaid Inquiry hours are 8:00 a.m. to 5:00 p.m. central time, Monday through Friday.

The status of a prior authorization can be obtained by calling 402-471-9771.

Claim Adjustments and Refunds: See 471-000-99 for instructions on requesting adjustments and refund procedures for claims previously processed by Nebraska Medicaid.

Medical and Surgical Services of a Dentist or Oral Surgeon: Medically necessary services not covered in 471 NAC 6-000 - Dental services may qualify for coverage through the Medicaid Physician Program. The Physician program policy is in 471 NAC 18-000.

Services are billed on a CMS-1500, "Health Insurance Claim Form" (see 471-000-62) or electronically using the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). Physician program services are billed with HCPCS/CPT procedure codes.

Client enrollment in Nebraska Health Connection managed care plans should be checked before providing services that will be billed through the Physicians program. See 471-000-122 for a listing of managed care plans and vendors.

ADA Dental Claim Form

HEADER INFORMATION

PRIMARY SUBSCRIBER INFORMATION

PRIMARY PAYER INFORMATION

OTHER COVERAGE

PATIENT INFORMATION

RECORD OF SERVICES PROVIDED

MISSING TEETH INFORMATION

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

AUTHORIZATIONS

ANCILLARY CLAIM/TREATMENT INFORMATION

BILLING DENTIST OR DENTAL ENTITY

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

American Dental Association, 2002

2002 ADA Dental Claim Form:

1. TYPE OF TRANSACTION: Check the appropriate box, "Statement of Actual Services", or "Request for Predetermination/Pre-authorization."

4-11. Complete if the patient has other dental coverage in addition to Medicaid.

* 15. SUBSCRIBER IDENTIFIER: Enter the patients eleven-digit Medicaid identification number (example: 123456789-01). When billing for pregnancy-related services provided to the ineligible mother of an eligible unborn child, enter the Medicaid number of the unborn child (See 471 NAC 1-002.02K3).

* 20. NAME: Enter the full name (first, middle initial, last name) of the patient.

* 21. DATE OF BIRTH: Enter the patients month, day and year of birth.

* 22. GENDER: Necessary for identification purposes.

23. PATIENT ID/ACCOUNT#: (Optional) You may enter the dental office patient account number. It will appear on the Medicaid "Explanation of Medical Activity" report.

** 24. PROCEDURE DATE: Complete when the service has been performed. Procedure codes listed without a date of service cannot be processed for payment.

* 27. TOOTH NUMBER(S) OR LETTER(S): Nebraska Medicaid accepts the Universal/National System tooth numbering system. Only one tooth number or letter will be processed per line.

* 28. TOOTH SURFACE: Designate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces.

* 29. PROCEDURE CODE: Enter the appropriate 5 digit ADA procedure code.

* 30. DESCRIPTION: Use ADA dental procedure descriptions for the service. For miscellaneous codes include a description of the service provided.

* 31. FEE: Enter the dentist full fee for the procedure reported, except when submitting for payment of prior authorized orthodontic treatment. When submitting for payment of orthodontic treatment the fee should be the amount prior authorized on the MC-9D form.

** 32. OTHER FEE(S): Enter any payment made, due, or obligated from other sources for services listed on this claim. Other sources include health insurance, liability insurance, excess income, etc. DO NOT enter previous Medicaid payments, Medicaid co-payment amounts, or the difference between the provider's billed charge and the Medicaid allowable fee in this field.

** 33. TOTAL FEE: This total is the amount for all services listed less any amount listed in field #32.

* 34. Place an "X" on each missing tooth.

35. REMARKS: Use to indicate any information, which you feel may be helpful in determining the benefits for the treatment. If space is inadequate, attach a separate sheet.

36-37. Completion not required. Medicaid payment is made to the dental provider. Payment can not be made to the Medicaid patient.

* 38. PLACE OF TREATMENT: Check the appropriate place of treatment.

* 39. NUMBER OF ENCLOSURES: Indicate whether radiograph(s), oral image(s) or model(s) are enclosed and the number enclosed.

* 40. IS TREATMENT FOR ORTHODONTICS: Indicate whether pre-authorization request is for orthodontics.

* 41. DATE APPLIANCE PLACED: Complete if orthodontic treatment was started prior to Medicaid eligibility. Orthodontic treatment requires prior authorization.

* 42. MONTHS OF TREATMENT REMAINING: Complete if orthodontic treatment already started.

* 43. REPLACEMENT OF PROSTHESIS: Complete when requesting prosthetic appliances.

* 44. DATE PRIOR PLACEMENT: Date of prior placement is needed to review prior authorization requests for replacement dentures or partials, and when submitting for payment for dentures or partials.

45. TREATMENT RESULTING FROM: Check appropriate box.

46. DATE OF ACCIDENT: Self explanatory.

47. AUTO ACCIDENT STATE: Self explanatory.

* 48. BILLING DENTIST OR DENTAL ENTITY: Enter the individual dentist's name or the name of the group practice/corporation, street address, city, state and zip code. This address should be the same as the address on your Medicaid provider agreement.

* 49. BILLING DENTISTS PROVIDER I.D.: Enter the eleven-digit Nebraska Medicaid provider number as assigned by the Department of Health and Human Services Finance and Support (example 123456789-01).

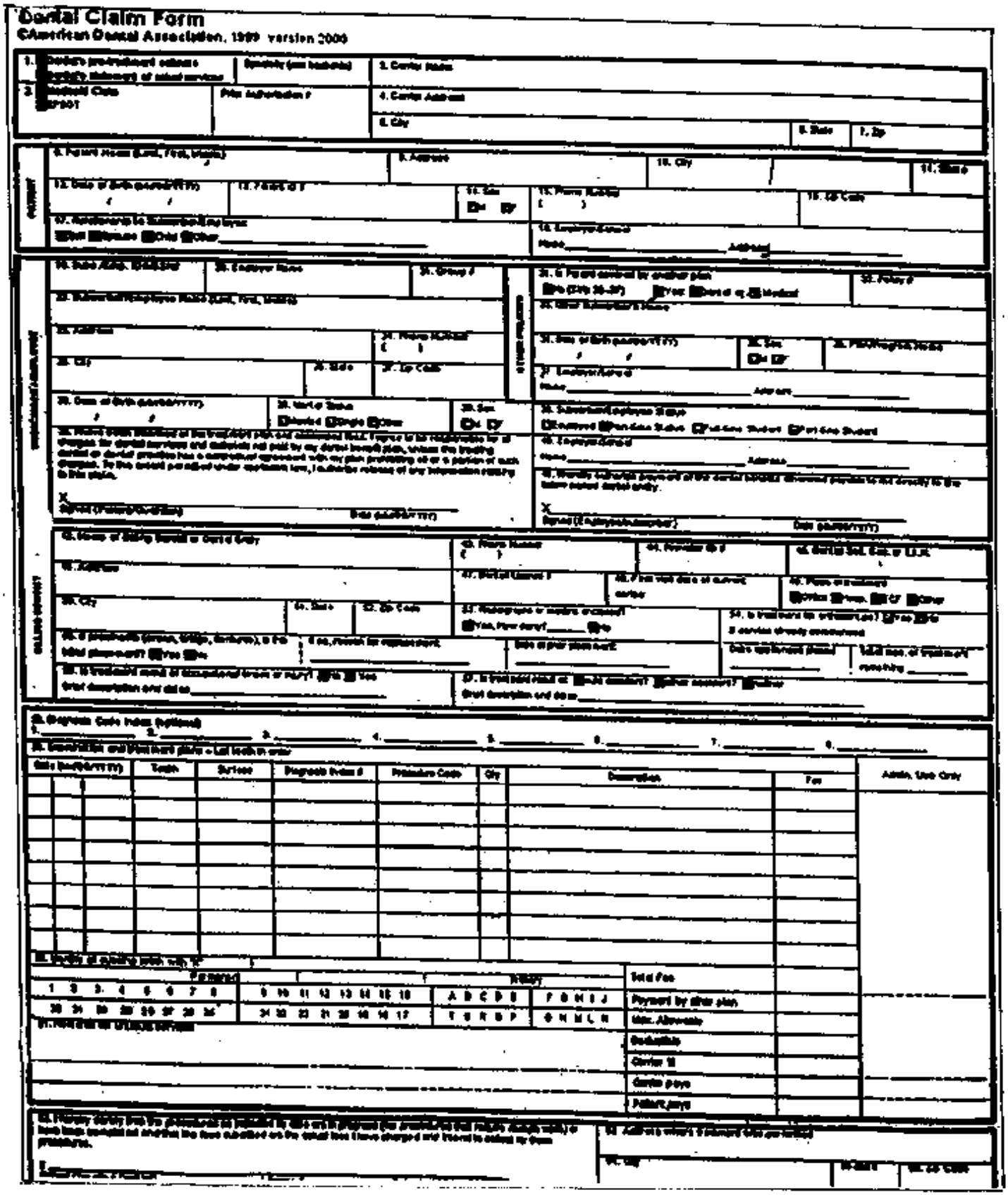
** 53. TREATING DENTIST – Signature: The dentist or authorized representative must sign and date the claim form. A signature stamp, computer generated or typed signature will be accepted, but the statement "signature on file" cannot be accepted. Unsigned claims can not be processed for payment.

** 54. TREATING DENTIST PROVIDER ID: Complete if enrolled as a group provider. Enter the social security number of the dentist providing the services listed on the claim. Payment is made to the provider I.D. in Field #49.

** 55. TREATING DENTIST LICENSE NUMBER: Enter the license number of the dentist providing the services listed on the claim.

** 56. ADDRESS, CITY STATE, ZIP CODE: Enter the full address where treatment was performed. If treatment was performed in a extended care facility, hospital or ambulatory surgical center include the name of the facility with the address. If the services were performed in the person's home, state "Person's Home," and provide the address.

* 57. PHONE NUMBER: Enter the treating dentist office telephone number, including the area code.



Dental Claim Form

©American Dental Association, 1999 version 2000

1999 ADA Dental Claim Form:

1. DENTIST'S PRE-TREATMENT ESTIMATE, OR DENTIST'S STATEMENT OF ACTUAL SERVICES: Check the appropriate box.

* 8. PATIENT NAME: Enter the full name (first, middle initial, last name) of the patient.

* 12. PATIENT DATE OF BIRTH: Enter the patients month, day and year of birth.

13. PATIENT ID#: (Optional) You may enter the dental office patient account number. It will appear on the Medicaid "Explanation of Medical Activity" report.

* 14. SEX: Necessary for identification purposes.

* 19. SUBS/EMP. ID#/SS#: Enter the patients eleven-digit Medicaid identification number (example: 123456789-01). When billing for pregnancy-related services provided to the ineligible mother of an eligible unborn child, enter the Medicaid number of the unborn child (See 471 NAC 1 -002.02K3).

31-41. IS PATIENT COVERED BY ANOTHER PLAN: Complete if the patient has other dental coverage in addition to Medicaid.

* 42. NAME OF BILLING DENTIST OR DENTAL ENTITY: Enter the individual dentist's name or the name of the group practice/corporation responsible for billing.

* 43. PHONE NUMBER: Enter the office telephone number, including area code.

* 44. PROVIDER ID#: Enter the eleven-digit Nebraska Medicaid provider number as assigned by the Department of Health and Human Services Finance and Support (example 123456789-01).

** 45. DENTIST SOCIAL SECURITY OR T.I.N.: Complete if enrolled as a group provider. Enter the social security number of the dentist providing the services listed on the claim. Payment is made to the provider I.D. in field #44.

* 46. ADDRESS: Enter the provider's street address.

** 47. DENTIST LICENSE #: Enter the license number of the dentist providing the services listed on the claim.

48. FIRST VISIT DATE OF CURRENT SERIES: Enter the first date of treatment.

* 49. PLACE OF TREATMENT, OFFICE, HOSPITAL, EXTENDED CARE FACILITY (ECF), OTHER: Check the appropriate place of treatment. IF BILLING TELEHEALTH SERVICES, CHECK "OTHER."

* 50-52. CITY, STATE, ZIP CODE: Self-explanatory.

* 53. RADIOGRAPHS OR MODELS ENCLOSED? Indicate whether radiograph(s) are enclosed and the number enclosed.

* 54. IS TREATMENT FOR ORTHODONTICS? YES, NO. IF SERVICES ALREADY COMMENCED: DATE APPLIANCE PLACED, TOTAL MONTHS OF TREATMENT REMAINING: Complete if orthodontic treatment was started prior to Medicaid eligibility. Orthodontic treatment requires prior authorization.

* 55. IF PROSTHESIS (CROWN, BRIDGE, DENTURES), IS THIS INITIAL PLACEMENT? YES, NO: IF NO, REASON FOR REPLACEMENT: DATE OF PRIOR PLACEMENT: Complete when requesting prosthetic appliances. Date of prior placement is needed to review prior authorization requests for replacement dentures or partials, and when submitting for payment for dentures or partials.

56. IS TREATMENT RESULT OF OCUPATIONAL ILLNESS OR INJURY? NO, YES: Check the appropriate box. If answer YES, please explain.

57. IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT? NEITHER: Check the appropriate box. If answer YES, please explain.

59. EXAMINATION AND TREATMENT PLANS:

** • Date: Complete when the service has been performed. Procedure codes listed without a date of service cannot be processed for payment.

* • Tooth: Nebraska Medicaid accepts the Universal/National System tooth numbering system. Only one tooth number or letter will be processed per line.

* • Surfaces: Designate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces.

* • Procedure Code: Enter the appropriate 5 digit ADA procedure code. If billing Telehealth transmission costs, use procedure code T1014, put the number of minutes of transmission in the Quantity column.

* • Qty: List the quantity of services provided.

* • Description: Use ADA dental procedure descriptions for the service. For miscellaneous codes include a description of the service provided.

* • Fee: Enter the dentists full fee for the procedure reported, except when submitting for payment of prior authorized orthodontic treatment. When submitting for payment of orthodontic treatment the fee should be the amount prior authorized on the MC-9D form.

** • Total Fee: This total is the amount for all services listed.

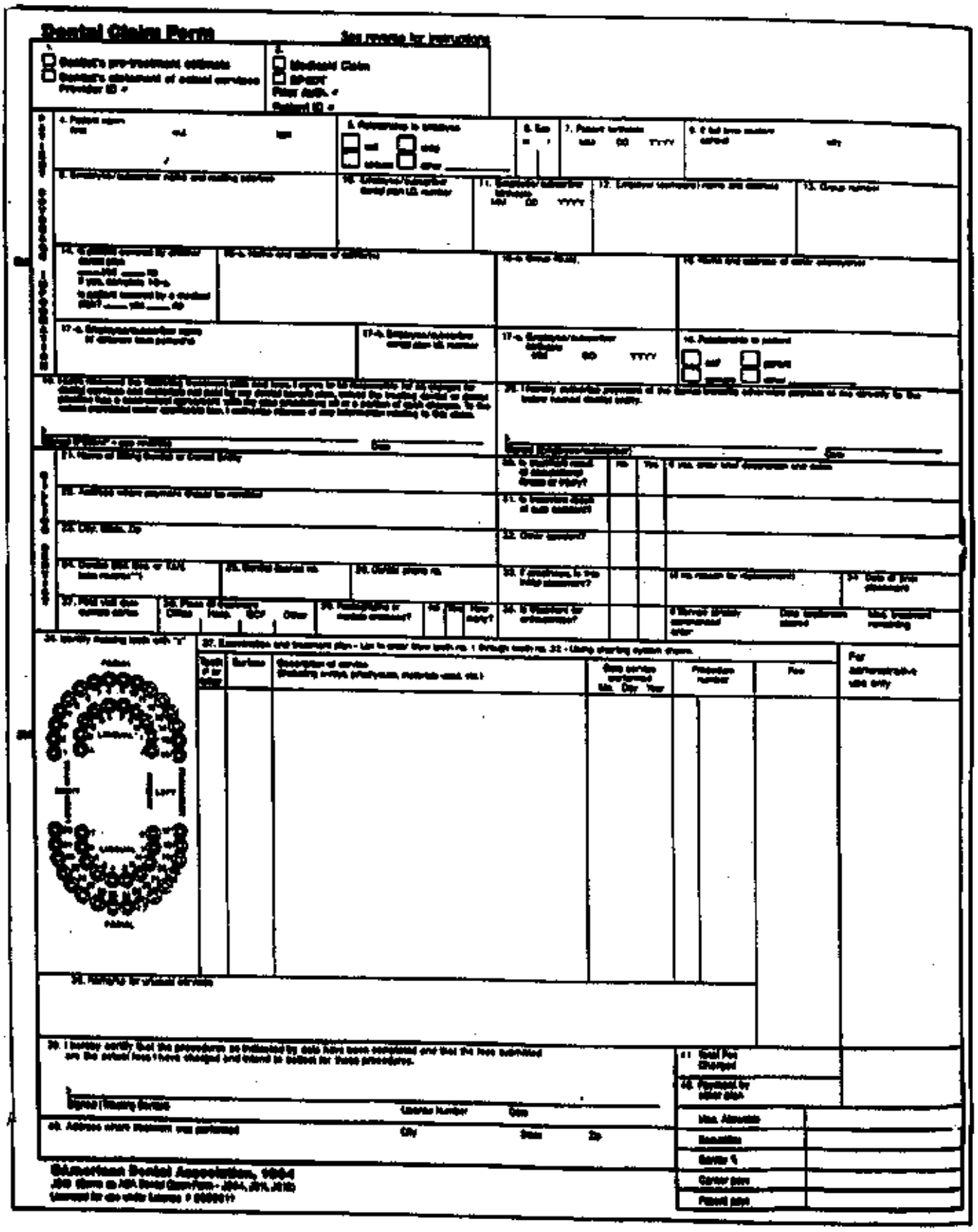
** • Payment By Other Plan: Enter any payment made, due, or obligated from other sources for services listed on this claim. Other sources include health insurance, liability insurance, excess income, etc. DO NOT enter previous Medicaid payments, Medicaid co-payment amounts, or the difference between the provider's billed charge and the Medicaid allowable fee in this field.

* 60. IDENTIFY ALL MISSING TEETH WITH "X": Place an "X" on each missing tooth.

61. REMARKS FOR UNUSUAL SERVICES: Use to indicate any information, which you feel may be helpful in determining the benefits for the treatment. If space is inadequate, attach a separate sheet.

** 62. DENTIST'S SIGNATURE BLOCK: The dentist or authorized representative must Sign and Date the claim form. A signature stamp, computer generated or typewritten signature will be accepted, but the statement "Signature on File" cannot be accepted. Unsigned claims can not be processed for payment.

** 63. ADDRESS WHERE TREATMENT WAS PERFORMED: Complete if the treatment was performed at a different location than the dentist office. If services were performed in an extended care facility, hospital or ambulatory surgical center include the name of the facility with the address. If the services were performed in the person's home, state "Person's Home," and provide the address.



1994 ADA Dental Claim Form:

1. DENIST'S PRE-TREATMENT ESTIMATE OR STATEMENT OF ACTUAL SERVICES: Check the appropriate box.

* PROVIDER IDENTIFICATION NUMBER: Enter the eleven-digit Nebraska Medicaid provider number as assigned by the Department of Health and Human Services Finance and Support (example 123456789-01).

* 2. PATIENT I.D. NUMBER: Enter the patients eleven-digit Medicaid identification number (example 123456789-01). When billing for pregnancy-related services provided to the ineligible mother of an eligible unborn child, enter the Medicaid number of the unborn child (See 471 NAC 1-002.02K3).

* 4. PATIENT NAME: Enter the full name (first, middle initial, last name) of the patient.

* 6. SEX: Necessary for identification purposes.

* 7. PATIENT BIRTHDATE: Enter the patients month, day and year of birth.

14-18. Complete if the patient has other dental coverage in addition to Medicaid.

17b. EMPLOYEE/SUBSCRIBER DENTAL PLAN I.D. NUMBER: (Optional) You may enter the dental office patient account number. It will appear on the Medicaid "Explanation of Medical Activity" report.

* 21. NAME OF BILLING DENTIST OR DENTAL ENTITY: Enter the provider's name.

* 22-23. ADDRESS WHERE PAYMENT SHOULD BE REMITTED: Enter the providers address.

** 24. DENTIST SOC. SEC. OR T.I.N.: Complete if enrolled as a group provider. Enter the social security number of the dentist providing the services listed on the claim. Payment is made to the provider identification number in field #1.

** 25. DENTIST LICENSE NO.: Enter the license number of the dentist providing the services listed on the claim.

* 26. DENTIST PHONE NUMBER: Enter the treating dentist office telephone number, including the area code.

27. FIRST VISIT DATE CURRENT SERIES: Enter the first date of treatment.

* 28. PLACE OF TREATMENT: Enter the place of treatment.

* 29. RADIOGRAPHS OR MODELS ENCLOSED? Indicate whether x-rays and/or models are enclosed AND the number enclosed.

30. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?: Check the appropriate box. If answered YES, please explain in detail.

31. IS TREATMENT RESULT OF AUTO ACCIDENT?: Check the appropriate box. If answered YES, please explain in detail.

32. OTHER ACCIDENT?: Check the appropriate box. If answered YES, please explain in detail.

* 33. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?: Complete when requesting prosthetic appliances.

* 34. DATE OF PRIOR PLACEMENT: Complete when requesting prosthetic appliances as applicable to replacement prosthetic appliances.

35. IS TREATMENT FOR ORTHODONTICS?: Complete when orthodontic treatment was started prior to Medicaid eligibility and request is for completion of orthodontic treatment. Orthodontic Treatment requires prior authorization.

* 36. IDENTIFY MISSING TEETH WITH "X": Put an "X" on each missing tooth.

37. EXAMINATION AND TREATMENT PLAN:

* • Tooth # or Letter:, Nebraska Medicaid accepts the Universal/National System tooth number system. Only one tooth number or letter will be processed per line.

* • Surface: Designate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces.

* • Description of Service: Use ADA dental procedure descriptions for the service. For miscellaneous codes include a description of the service provided.

** • Date Service Performed MO/DAY/YEAR: Complete when the service has been performed. Procedure codes listed without a date of service cannot be processed for payment.

* • Procedure Number: Enter the appropriate 5 digit ADA procedure code.

* • Fee: Enter the dentist full fee for the procedure reported, except when submitting for payment of prior authorized orthodontic treatment. When submitting for payment of orthodontic treatment the fee should be the amount prior authorized on the MC-9D form.

38. REMARKS FOR UNUSUAL SERVICES: Use to indicate any information, which you feel may be helpful in determining the benefits for the treatment. If space is inadequate, attach a separate sheet.

** 39. DENTIST'S SIGNATURE BLOCK: The dentist or authorized representative must Sign and Date the claim form. A signature stamp, computer generated or typewritten signature will be accepted, but the statement "Signature on File" cannot be accepted. Unsigned claims can not be processed for payment.

* 40. ADDRESS WHERE TREATMENT WAS PERFORMED: Complete if the treatment was performed at a different location than the dentist office. If services were performed in an extended care facility, hospital or ambulatory surgical center include the name of the facility with the address. If the services were performed in the person's home, state "Person's Home," and provide the address.

** 41. TOTAL FEE CHARGED: This total is the amount for all services listed.

** 42. PAYMENT BY OTHER PLAN: Enter any payment made, due, or obligated from other sources for services listed on this claim. Other sources include health insurance, liability insurance, excess income, etc. DO NOT enter previous Medicaid payments, Medicaid co-payment amounts, or the difference between the provider's billed charge and the Medicaid allowable fee in this field.